



Life
Saving
Commodities
Improving access,
saving lives

**Demand Generation for Reproductive, Maternal,
Newborn and Child Health Commodities**

AN ADAPTABLE COMMUNICATION STRATEGY FOR MISOPROSTOL

JULY 2014



USAID
FROM THE AMERICAN PEOPLE



**HEALTH
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COLLABORATIVE**

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Acronyms

AMTSL	Active management of the third stage of labor
ANC	Antenatal care
CBO	Community-based organization
CCP	Johns Hopkins Center for Communication Programs
CHW	Community health worker
DHS	Demographic and Health Surveys
EWEC	Every Woman Every Child
FIGO	International Federation of Gynecology and Obstetrics
HC3	Health Communication Capacity Collaborative
HEW	Health extension worker
ICM	International Confederation of Midwives
ICT	Information and communication technology
IPC	Interpersonal communication
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Non-governmental organization
PPP	Public-private partnership
PSA	Public service announcement
RMNCH	Reproductive, maternal, newborn and child health
SBA	Skilled birth attendant
SBCC	Social and behavior change communication
SM	Social marketing
SMS	Short message service
TBA	Traditional birth attendant
UN	United Nations
UNCoLSC	United Nations Commission on Lifesaving Commodities for Women's and Children's Health
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

Introduction



Aim

To provide step-by-step guidance and illustrative content in creating a communication strategy to generate demand for **misoprostol**.

Intended User

This Adaptable Communication Strategy (the Strategy) is designed to be useful to multiple audiences, including staff from ministries of health, non-governmental organizations (NGOs) and community-based organizations (CBOs). The Strategy can support the efforts of communication professionals working directly on behavior change communication programs, as well as other professionals working in reproductive, maternal, newborn and child health (RMNCH) who need to create a demand generation component to support program activities.

What is a Communication Strategy?

A communication strategy provides a “road map” for local action targeted at behavior change and creates a consistent voice for the messages, materials and activities developed. It also ensures that activities and products work together to achieve the program goal and objectives. The final communication strategy should be used to guide content development of program materials, such as advocacy briefs, client leaflets, and job aides and tools for health providers, thereby ensuring consistent positioning and messaging across all activities.

The communication strategy, however, is not a static product. It must be responsive to an ever-changing environment. Adaptations may be necessary in order to respond to new research findings and data, unexpected events, changing priorities or unforeseen results. Communication strategies are essential in addressing priority or emergent health issues and allow for harmonization of priorities, approaches and messages among all the relevant organizations and stakeholders.

How to Use this Adaptable Communication Strategy

This Strategy forms part of a comprehensive Demand

Generation Implementation Kit for Underutilized Commodities in RMNCH (the *I-Kit*) (<http://sbccimplementationkits.org/demandrmnch>). The *I-Kit* includes commodity-specific communication strategies designed to be easily adapted across multiple country contexts and integrated into existing RMNCH plans. The *I-Kit* also includes resources on four core cross-cutting demand generation areas: addressing the role of gender, a theory-based framework for media selection, utilizing information and communication technologies (ICTs) and new media, and leveraging public-private partnerships (PPPs).

This Strategy is not intended to serve as a “one-size-fits-all” model. It is designed as a quick-start foundation based on available evidence to provide guidance in answering the following questions:

- Where are we now?
- What is our vision?
- How are we going to achieve our vision?
- How do we know we achieved our vision?

Ideally, country-level teams would then integrate commodity-specific content tailored to the country context into existing or new RMNCH communication strategies for demand generation.

It is important to note that the strategy focuses on communication—typically, the product promotion component of a social marketing (SM) approach. If desired, the strategy can be integrated and expanded into a broader SM framework, addressing product, price and place.

Thirteen Lifesaving Commodities for Women and Children

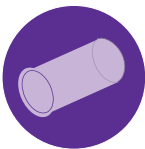












In 2010, the United Nations (UN) Secretary-General’s *Global Strategy for Women’s and Children’s Health* (the Global Strategy) highlighted the impact that a lack of access to lifesaving commodities has on the health of women and children around the world. The Global Strategy called on the global community to save 16 million lives by 2015 by increasing access to and appropriate use of essential medicines, medical devices and health supplies that effectively address the leading avoidable causes of death during pregnancy, childbirth and childhood. Under the

Every Woman Every Child (EWEC) movement, and in support of the Global Strategy and the Millennium Development Goals (MDGs) 4 and 5, the UN Commission on Lifesaving Commodities (UNCoLSC) for Women's and Children's Health (the Commission) was formed in 2012 to catalyze and accelerate reduction in mortality rates of both women and children. The Commission identified 13 overlooked

lifesaving commodities across the RMNCH "Continuum of Care" that, if more widely accessed and properly used, could save the lives of more than six million¹ women and children. For additional background information on the Commission, please refer to <http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities>.

¹For assumptions used to estimate lives saved see UNCoLSC Commissioner's report (annex) (http://www.everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf)

Figure 1: 13 Lifesaving Commodities

Reproductive Health			
 <p>Female Condoms</p>	 <p>Contraceptive Implants</p>	 <p>Emergency Contraception</p>	
<p>Prevent HIV and unintended pregnancy: A female condom (FC) is a plastic pouch made of polyurethane that covers the cervix, vagina and part of the external genitals. FCs provide dual protection by preventing STI infection, including HIV, and unintended pregnancies.</p>	<p>Prevent unintended pregnancy: Contraceptive implants are small, thin, flexible plastic rods inserted into a woman's arm that release a progestin hormone into the body. These safe, highly effective, and quickly reversible contraceptives prevent pregnancy for three to five years.</p>	<p>Prevent unintended pregnancy: The emergency contraceptive pill is the most widely available emergency contraceptive in developing countries. It is optimally taken in one dose of 1.5mg as soon as possible after sexual activity. An alternative product of 0.75mg is also widely available.</p>	
Maternal Health			
 <p>Oxytocin</p>	 <p>Misoprostol</p>	 <p>MgSO₄ Magnesium Sulfate</p>	
<p>Post-partum hemorrhage: WHO recommends oxytocin as the uterotonic of choice for prevention and management of postpartum hemorrhage.</p>	<p>Post-partum hemorrhage: In settings where skilled birth attendants are not present and oxytocin is unavailable, misoprostol (600 micrograms orally) is recommended.</p>	<p>Eclampsia and severe pre-eclampsia: WHO recommends MgSO₄ as the most effective treatment for women with eclampsia and severe pre-eclampsia.</p>	
Child Health			
 <p>Amoxicillin</p>	 <p>Oral Rehydration Salts</p>	 <p>Zn Zinc</p>	
<p>Pneumonia: Amoxicillin is an antibiotic that is used to treat pneumonia in children under five. Amoxicillin is prepared in 250mg scored, dispersible tablet (DT) in a blister pack of 10 DTs.</p>	<p>Diarrhea: Oral rehydration salts (ORS) is a glucose-electrolyte solution given orally to prevent dehydration from diarrhea. ORS is packaged in sachets of powder to be diluted in 200 ml, 500 ml or 1 liter of fluid, prepared to an appropriate flavor.</p>	<p>Diarrhea: Replenishment with zinc can reduce the duration and severity of diarrheal episodes. Zinc is prepared either in 20mg scored, taste masked, dispersible tablets or oral solutions at concentration of 10mg/5ml.</p>	
Newborn Health			
 <p>Injectable Antibiotics</p>	 <p>Antenatal Corticosteroids</p>	 <p>Chlorhexidine</p>	 <p>Resuscitation Device</p>
<p>Prevent newborn sepsis: WHO recommends benzylpenicillin and gentamicin, in separate injections, as first-line therapy for presumptive treatment in newborns at risk of bacterial infection.</p>	<p>Prevent pre-term RDS: Antenatal corticosteroids are given to pregnant women who are at risk of preterm delivery to prevent respiratory distress syndrome in babies born in pre-term labor.</p>	<p>Prevent umbilical cord infection: Chlorhexidine digluconate is a low-cost antiseptic for care of the umbilical cord stump that is effective against neonatal infections.</p>	<p>Treat asphyxia: Birth asphyxia, or the failure of a newborn to start breathing after birth, can be treated with resuscitation devices.</p>

Demand Generation: An Overview



What is Demand Generation?

Demand generation increases awareness of and demand for health products or services among an intended audience through social and behavior change communication (SBCC) and SM techniques. Demand generation can occur in three ways:

- **Creating new users**—convincing members of the intended audience to adopt new behaviors, products or services.
- **Increasing demand among existing users**—convincing current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products or services.
- **Taking market share from competing behaviors** (e.g., convincing caregivers to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or has been compromised) and products or services (e.g., convincing caregivers to use oral rehydration salts (ORS) and zinc instead of other anti-diarrheal medicines).

When well designed and implemented, demand generation programs can help countries reach the goal of increased utilization of the commodities by:

- Creating informed and voluntary demand for health commodities and services.
- Helping health care providers and clients interact with each other in an effective manner.

- Shifting social and cultural norms that can influence individual and collective behavior related to commodity uptake.
- Encouraging correct and appropriate use of commodities by individuals and service providers alike.

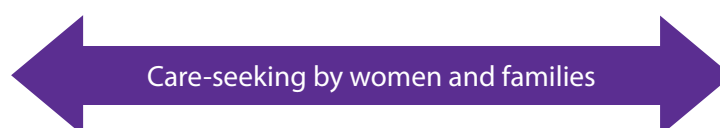
In order to be most effective, demand generation efforts should be matched with efforts to improve logistics and expand services, increase access to commodities, and train and equip providers, in order to meet increased demand for products and/or services. Without these simultaneous improvements, the intended audience may become discouraged and demand could then decrease. Therefore, it is highly advisable to coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programs.

Who are the Audiences of Demand Generation Programs for the 13 Lifesaving Commodities?

Reducing maternal and child morbidity and mortality through increased demand for and use of RMNCH commodities depends on the collaboration of households, communities and societies, including mothers, fathers and other family members, community- and facility-based health workers, leaders and policy makers. Some of the commodities are more provider-focused in terms of demand and utilization, but all depend on the care-seeking behaviors of women and families.

Figure 2: Audiences of Demand Generation

Provider-focused	Provider and End-user
<input type="checkbox"/> Oxytocin	<input type="checkbox"/> Female condoms
<input type="checkbox"/> Magnesium sulfate	<input type="checkbox"/> Implants
<input type="checkbox"/> Injectable antibiotics	<input type="checkbox"/> Emergency contraception
<input type="checkbox"/> Antenatal corticosteroids	<input type="checkbox"/> Misoprostol
<input type="checkbox"/> Resuscitation equipment	<input type="checkbox"/> Chlorhexidine
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> ORS
	<input type="checkbox"/> Zinc



Key Concepts and Definitions in Demand Generation

Social and Behavior Change Communication (SBCC). SBCC promotes and facilitates behavior change and supports broader social change for the purpose of improving health outcomes. SBCC is guided by a comprehensive ecological theory that incorporates both individual-level change and change at the family, community, environmental and structural levels. A strategic SBCC approach follows a systematic process to analyze a problem in order to define key barriers and motivators to change, and then design and implement a comprehensive set of interventions to support and encourage positive behaviors. A communication strategy provides the guiding design for SBCC campaigns and interventions, ensuring communication objectives are set, intended audiences are identified and consistent messages are determined for all materials and activities.

Social Marketing (SM). SM seeks to develop and integrate marketing concepts (product, price, place and promotion) with other approaches to influence behaviors that benefit individuals and communities for the greater social good. (http://socialmarketing.blogs.com/r_craig_lefebvres_social/2013/10/a-consensus-definition-of-social-marketing.html)

Channels and Approaches

Advocacy. Advocacy processes operate at the political, social and individual levels, and work to mobilize resources and political and social commitment for social and/or policy change. Advocacy aims to create an enabling environment to encourage equitable resource allocation and remove barriers to policy implementation.

Community Mobilization. Community mobilization is a capacity building process through which individuals, groups or organizations design, conduct and evaluate activities on a participatory and sustained basis. Successful community mobilization works to solve problems at the community level by increasing the ability of communities to successfully identify and address their needs.

Entertainment Education. Entertainment education is a research-based communication process or strategy of deliberately designing and implementing entertaining educational programs that capture audience attention in order to increase knowledge about a social issue, create favorable attitudes, shift social norms and change behavior.

Information and Communication Technologies (ICTs). ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of media, which include mobile and smart phones, short message service (SMS) and social media, such as Facebook and Twitter.

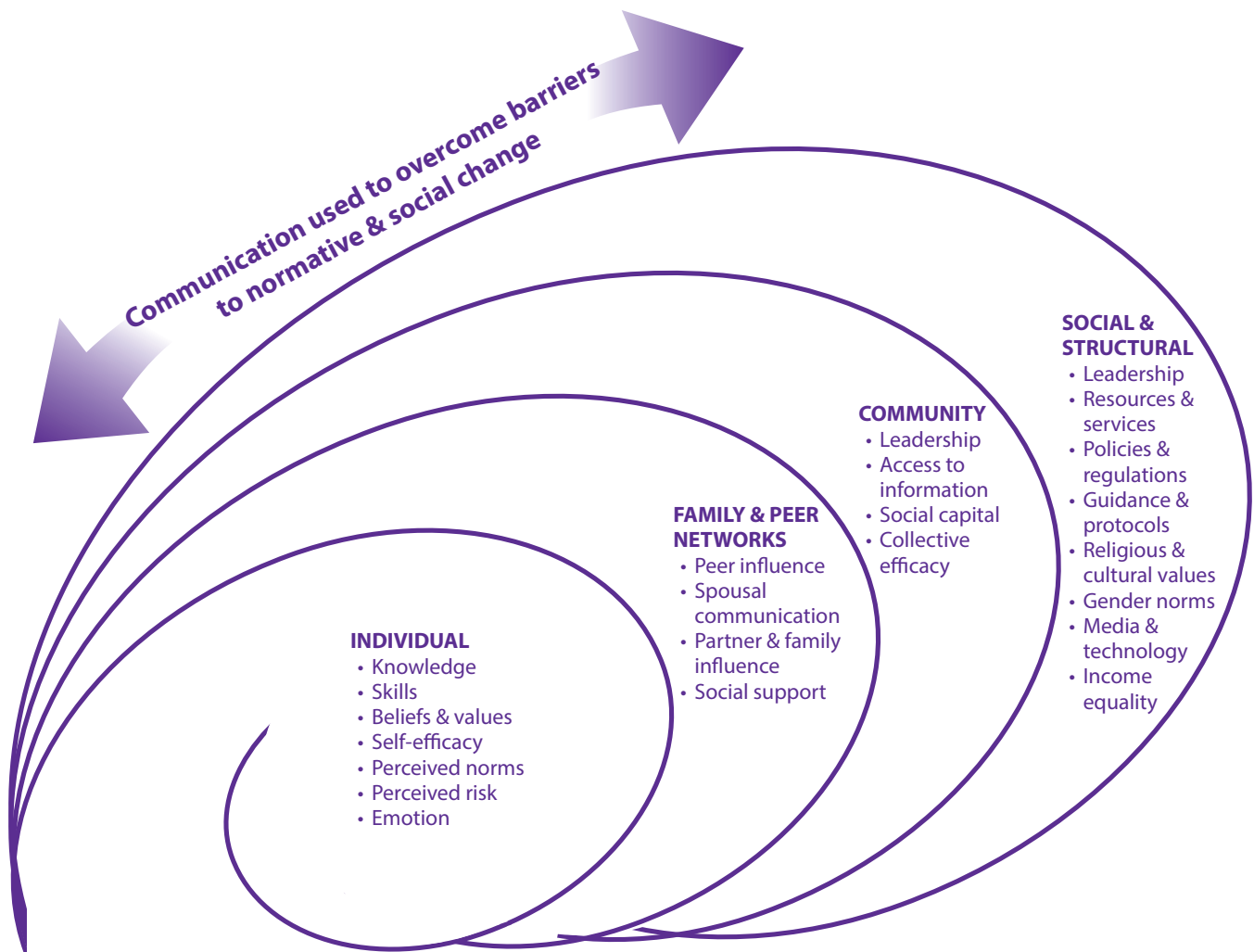
Interpersonal Communication (IPC). IPC is based on one-to-one communication, including, for example, parent-child communication, peer-to-peer communication, counselor-client communication or communication with a community or religious leader.

Mass and Traditional Media. Mass media reaches audiences through radio, television and newspaper formats. Traditional media is usually implemented within community settings and includes drama, puppet shows, music and dance. Media campaigns that follow the principles of effective campaign design and are well executed can have a significant effect on health knowledge, beliefs, attitudes and behaviors.

Conceptual Framework

This Strategy uses the social ecological framework to guide its strategic design. This model recognizes that behaviors related to demand for care and treatment take place within a complex web of social and cultural influences and views individuals as nested within a system of socio-cultural relationships—families, social networks, communities, nations—that are influenced by and have influence on their physical environments (Bronfenbrenner, 1979; Kincaid, Figueroa, Storey,

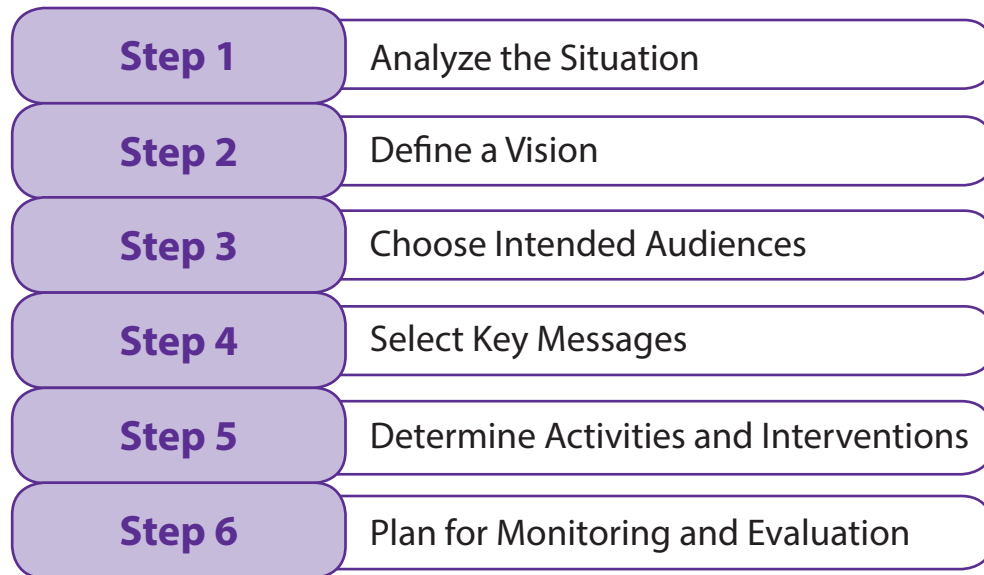
& Underwood, 2007). Within this framework, individuals’ decisions and behaviors, relating to an increase in demand and utilization, are understood to depend on their own characteristics, as well as the social and environmental contexts within which they live. Applying this model in each stage of the communication strategy development helps to ensure that all determinants of behavior are considered and addressed.



Adaptable Communication Strategy: Structure and Guidance



This strategy presents a six-step process to guide country-level adaptation based on local situation analysis and formative research:



Explanations of each step begin below. Illustrative content for each step follows in the next section.

Who should be involved in strategy development?

Developing a communication strategy typically involves convening a group of stakeholders—ideally including representatives of the government, health area experts, marketing or communication specialists, and members of intended audiences—to review existing data, identify key audiences, and develop messaging and appropriate communication channels. Other potential partners may include private sector representatives for the formation of PPPs, which can be used to strengthen a demand generation program, based on the needs and opportunities within an individual country context.

Step 1: Analyze the Situation

What is a situation analysis?

The situation analysis focuses on gaining a deeper understanding of the challenges and barriers to address within a specific context that influence the current demand and utilization of a priority RMNCH commodity, including those affected and their perceived needs; social and cultural norms; potential constraints on and facilitators for individual and

collective change; and media access and use by the intended audiences. It also examines the status of the lifesaving commodity, including relevant policies, regulations, manufacturing, prices, supply chains, availability, level of knowledge (provider and end user) and level of use (provider and end user). In short, the situation analysis answers the question: “Where are we now?”

The situation analysis should also examine the attitudes, values, interests, aspirations and lifestyle of the intended audiences. This information, called psychographics, allows for a better understanding of what motivates and what hinders the intended audiences’ decisions and actions. Psychographics provide character sketches of the intended audiences that go beyond demographic information (sex, age, education, parity, etc.) and help to build a fuller picture of the audiences as individuals and how they may be nested within and influenced by their community.

Why conduct a situation analysis?

A comprehensive situation analysis is essential as it provides a detailed picture of the current state of the commodity, needs and barriers which will direct the design and implementation decisions of the strategy and ultimately affect the level of success in generating demand and use.

How to conduct a situation analysis

As noted above, conducting a situation analysis typically involves convening a group of stakeholders and reviewing existing data in order to identify key information. A global synthesis of evidence conducted for each of the 13 underutilized commodities can provide a global view of available information and lessons learned from other country contexts (available at <http://sbccimplementationkits.org/demandrmnch/evidence-synthesis>).

Additional sources of country-specific secondary data may include Demographic and Health Surveys (DHS) (<http://www.measuredhs.com/>), Multiple Indicator Cluster Surveys (MICS) (http://www.unicef.org/statistics/index_24302.html), quantitative and qualitative research conducted by NGOs, or private sector market research, where available, such as Nielsen (<http://www.nielsen.com/us/en.html>). RMNCH policies and guidelines also may assist in analyzing the situation.

If existing data, particularly on social and behavioral drivers and psychographics, is not sufficient, is outdated or does not provide enough insight into priority audiences, it may be necessary to conduct additional primary formative research in the form of focus groups, interviews or informal visits to communities and homes. For all provider audiences, it may be especially important to conduct formative research around provider attitudes and other drivers to provider behavior. Similarly, for all audiences (providers and end users), it may be especially important to conduct formative research to develop realistic psychographics.

What are the key questions?

The situation analysis has two main sections:

- Health and Commodity Context
- Audience and Communication Analysis

Health and Commodity Context

Below is an example of a set of questions to consider when analyzing the health and commodity-specific context relevant to misoprostol:

- What are the maternal, neonatal and child mortality rates in the country?

- How many maternal deaths result from postpartum hemorrhage (PPH)?
- What are the other costs of PPH (e.g., disability, need for transfusion)?
- What percentage of women deliver with a skilled birth attendant (SBA)? With traditional birth attendant (TBA)? Alone or with an unskilled family member?
- How is PPH currently prevented or treated in urban, rural and peri-urban settings? What is the first-line treatment? What other uterotonics (substances that give the uterine muscle tone, causing it to contract and thereby cause labor or reduce hemorrhage) are available and used? Where, how often and in what circumstances?
- What proportion of women giving birth receive a uterotonic to prevent PPH?
- Is misoprostol registered in the country? If registered, what brands? If not registered, what is the registration process—e.g., time, requirements?
- What regulations or policies govern supply, distribution and availability of misoprostol? How may these affect demand?
- What level of provider (doctor, nurse, midwife, etc.) is permitted to administer/dispense misoprostol? Are community health workers (CHWs), TBAs and other community-based health personnel permitted to provide misoprostol?
- What is the price of misoprostol in the private and public sectors?
- What are the costs of services associated with counseling, administration and follow-up?
- What is the availability of misoprostol? By region/district? By public/private sector?
- In what forms is it available (e.g., tablets: how many micrograms? How many per package)?
- If misoprostol is not available, what efforts are underway or could be taken to make it available?
- What proportion of women, disaggregated by age and location (and other characteristics as relevant), used misoprostol at last birth?
- What percentage of women uses uterotonics (chemical or herbal) for labor augmentation?
- What opportunities exist that can improve misoprostol demand and use?
- What patterns exist in uptake of misoprostol over the past five to ten years (increased, declined, remained static)?

Audience and Communication Analysis

Following is an example of a set of questions to consider when conducting audience and communication analysis:

Knowledge and Attitudes

- What proportion of providers, women, men and other audiences is aware of misoprostol?
- What proportion of providers, women, men and other audiences has accurate knowledge about misoprostol?
- What do the various cadres of health care providers—including SBAs, pharmacists, TBAs, CHWs and health promoters—know about PPH and about misoprostol?
- Are there common misconceptions or misinformation about PPH or misoprostol?
- What do women, their partners and other gatekeepers perceive as the benefits of using misoprostol?
- What do women, their partners and other gatekeepers perceive as barriers to using misoprostol (e.g., ability of misoprostol to abort)?
- How do providers perceive misoprostol versus other ways to prevent and treat PPH?
- How might use and perceptions of uterotonics, other than misoprostol, impact perceptions and use of misoprostol?
- What do women, their partners and other gatekeepers perceive as facilitators to using misoprostol?

Normative and Structural Considerations

- What are the gender norms in country among couples, both married and unmarried, and how do these affect misoprostol use?
- Under what circumstances is it acceptable to use misoprostol? Under what circumstances is it not acceptable?
- How does the level of income affect use of misoprostol? Do poorer women and couples have access to both information and product?
- Who in the family decides what level and type of prenatal, delivery and postpartum care women receive?
- To what extent is cost a factor in accessing prenatal, delivery and postpartum care?
- To what extent is culture or religion a factor in accessing prenatal, delivery and postpartum care, or in the availability of misoprostol?

- Who are the stakeholders, key players and gatekeepers who impact or influence demand and utilization of misoprostol?
- How are these stakeholders, key players and gatekeepers influencing demand and utilization of misoprostol?
- What existing channels (e.g., national health worker volunteer program) can be leveraged for reaching women, partners, gatekeepers and providers with information about PPH and misoprostol?
- To what extent is it believed that community-based distribution of misoprostol will lead to correct use by CHWs and/or pregnant women?

Service Provision

- What percentage of pregnant women seeks prenatal care?
- How early in the pregnancy do women seek prenatal care?
- What percentage of women requests uterotonics (chemical or herbal) for labor augmentation?
- Do counseling guidelines ensure adequate information on misoprostol, including side effects and use?
- Do providers have adequate skills to counsel, prescribe and/or administer misoprostol?
- To what extent are guidelines for uterotonic use and PPH management up-to-date, disseminated and followed?
- What other structural or health system barriers affect demand and use of misoprostol?

Media and Communication

- Do couples communicate about using misoprostol or similar commodities?
- Through what channels (including media and interpersonal) do providers, women and their partners prefer to receive health-related information?
- What communication materials and programs already exist related to PPH and misoprostol?
- What channels can support the level of communication needed to increase knowledge of PPH and demand for misoprostol?
- What is the technical and organizational capacity of media partners?

Psychographics

- What do providers, women and their partners' value? What are their core beliefs?
- Who and what influences providers, women and their partners' decisions and behaviors?
- What dreams do providers, women and their partners have? What do they aspire to in life?
- What are providers', women's and their partners' biggest worries? What fears keep them up at night?
- How do providers, women and their partners spend their days? Where do they go? What do they do? What are their hobbies and habits?
- How do providers, women and their partners perceive themselves? How do they want to be perceived by others?

How to use the situation analysis

After conducting a situation analysis, program managers should be able to identify the key implications or challenges from the data. What are the reasons that misoprostol is not being utilized? What do potential users—end user, health care providers and health educators—believe about the commodity? Finally, select only a few key factors that the demand generation strategy will address. While it is tempting to address all factors, communications programs will be more successful if they focus on the top few factors that will have the biggest impact given available resources.

It can be helpful to organize the collected information—in order to distill the most important information—using a simple table organized by intended audience, such as the one below.

	Current Behaviors	Primary Barriers to Desired Behavior	Primary Benefits of Desired Behavior
End user/community members (e.g. women, men, caregivers)			
Providers (including public and private, clinic- and community-based)			

In order to maintain an actionable focus throughout the strategy design, it is also helpful to synthesize the implications of this information. Population Services International's (PSI) Global Social Marketing

Department offers the following series of questions to guide the development of a situation analysis and the selection of strategic priorities to be addressed by the demand generation strategy:

What?	So What?	Now What?
Data Collection: Key facts collected during the situation analysis.	Data Analysis: Possible implications that the facts may have on the demand generation strategies.	Strategic Priorities: Identify which implications to address in the demand generation strategy. Limit to three to five strategic priorities in order to focus the plan.
Example for misoprostol:		
TBAs, midwives and health facilities are the main sources of information about bleeding after childbirth.	Telling pregnant women about excessive postpartum bleeding has not changed the fact the PPH is the number one or two leading cause of maternal mortality in many countries and settings. To significantly reduce deaths from PPH, those who deliver babies need be advised and enabled to have on hand an effective uterotonic to prevent or treat PPH.	Where a high proportion of births take place at home, having providers recommend misoprostol to women preparing for birth and making misoprostol available at community level becomes a strategic priority.

Source: Population Services International, n.d. The DELTA companion: Marketing planning made easy. (http://www.psi.org/sites/default/files/publication_files/DELTA%20Companion.pdf)

Step 2: Define a Vision

The vision anchors a communication strategy by stating what the program hopes to achieve. A vision statement sets forth the direction the strategy should follow and defines clearly and succinctly how the demand generation activities will affect the broader commodity and health environment. The vision should paint a mental picture of a desired scenario in the future.

The vision should be agreed upon by the stakeholders involved in the strategy design process and will thus be “shared” by all. This shared vision is a short statement that articulates what is important, illustrates what is desired in the future for the commodity once the demand generation strategy is successfully implemented and clarifies the goal of the demand generation strategy. The shared vision ensures that all stakeholders are working toward

the same goal and guides the strategy design and development process.

In addition, a true vision should be realistic, concrete and attainable given the resources available. The vision should also communicate enthusiasm, be inspirational, and foster commitment and dedication from stakeholders toward the shared goal.

Some organizations call the vision the “Goal” or the “Primary Objective.”

An example of a vision statement for misoprostol may be:

Providers, women, their partners and gatekeepers see misoprostol as a valuable tool to prevent and treat PPH, and they easily obtain and use it consistently at facilities and at the community level (when oxytocin is not available).

Step 3: Choose the Intended Audiences

Segment the Audiences

Segmentation is the process of identifying unique groups of people, within larger populations, which share similar interests and needs relative to the commodity. If the group shares common attributes, then the members are more likely to respond similarly to a given demand generation strategy. Segmenting allows for targeted use of limited resources to those populations that would most affect increased demand. It ensures that the activities developed and implemented are the most effective and appropriate for specific audiences, and are focused on customized messages and materials.

Using key findings collected from the situation analysis, the first step in audience segmentation is to answer the question, “Whose behavior must change in order to increase demand and appropriate use of the commodity?” Initial segmentation is often based on demographics, such as age, sex, marital status, education level, socio-economic status, employment and residence (urban/rural). Audiences can be further segmented by psychographics—people’s personalities, values, attitudes, interests and lifestyles.

Primary audiences are the key people to reach with messages. These may be the people who are directly affected and who would directly benefit from the use of the commodity. Or they may be the people who can make decisions on behalf of those who would benefit from the commodity. Primary audiences may be further segmented into sub-audiences. For example, identifying specific segments of women of reproductive age who may share common attributes, such as young unmarried women, married women or high parity women.

Influencing audiences are people who can impact or guide knowledge and behaviors of the primary audience, either directly or indirectly. Influencing audiences can include family members and people in the community, such as community leaders, but can also include people who shape social norms, influence policies or affect how people think about the commodity. Prioritizing key influencing audiences by an estimated power of influence related to increasing demand and uptake of the commodity is crucial. For example, male partners are a likely key influencing audience, but the level of influence (low, moderate, strong) may depend on country context and/or commodity, and should be discussed among stakeholders. In order to prioritize influencing audiences, a table like the one below can be helpful.

	Primary Audience Influenced	Estimated Power of Influence (Low, Moderate, Strong)	Attitude Toward Use of Misoprostol or Similar Commodities
Influencing Audience 1			
Influencing Audience 2			

Primary or influencing audiences for demand generation may also include national, sub-national or community-level decision makers, such as legislators and religious leaders, as they can be instrumental in removing or creating access barriers or spreading misguided beliefs about the product.

Involving decision makers and influencers from the political and media realm—and carefully considering the legal and policy environment—is important to ensure demand generation efforts are not hindered by political or social barriers. *Scaling Up Lifesaving Commodities for Women, Children and Newborns: An Advocacy Toolkit* (<http://www.path.org/publications/detail.php?i=2381>) provides advocacy resources to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. Therefore, advocacy audiences are not included in this communication strategy.

Develop Audience Profiles

Audience profiles are the cornerstone of a communication strategy. They first help bring to life and personify each audience segment, which subsequently guide communication messaging and activity planning. The profile should embody the characteristics of the specific audience, with a focus on telling the story of an imagined individual within the group who can neutrally represent the intended audience. Basing decisions on a representative, personalized example from a specific audience segment, rather than on a collection of statistics or a mass of anonymous people, allows for more intimate knowledge of that audience segment and better defined and focused communication strategies. Therefore, the profile is important to ensure the messages are tailored to members of this selected group, resonate with them and motivate them to take action.

Audience profiles for each audience segment are developed using the information collected in the situation analysis. The profile consists of a paragraph that should include details on psychographics, such as current behaviors, motivation, emotions, values, and attitudes, preferred sources of information and access to communication channels, as well as socio-demographic information, such as age, income level, religion, sex and place of residence. The profile should exemplify the primary barriers to the desired

behavior relative to the audience segment. The profile may include the name of this individual or a photo that represents this person to help visualize who this person is and tell his or her story. It is important to keep in mind that:

1. No two audience profiles look the same as the same data will not always be available for each audience segment.
2. The best profiles use qualitative research as a source.
3. Profiles are to be living documents and regularly updated when new information is available.

If the information gathered in the situation analysis lacks detail on a particular audience segment, additional research may need to be conducted to address the identified gaps. For example, for all provider audiences, it may be especially important to conduct formative research around provider attitudes and other drivers to provider behavior that could be used to better inform the audience profile and strategic design.

Step 4: Design Message Strategy (Objectives, Positioning, Key Messages)

The message strategy is one of the most important elements of a communication strategy. It drives the rest of the program and ensures synergy, consistency and coordination for the purposes of shared objectives and clear, harmonized messaging among all stakeholders and partners. A message strategy is designed for each primary and influencing audience and includes: (a) communication objectives, (b) positioning and (c) key messages. As previously mentioned, audience profiles are used to determine whether or not the objectives, positioning and key messages are appropriate for that individual.

(a) Objectives

Communication objectives are measurable statements that clearly and concisely state what the target audience should know (think), what they should believe (feel) and what they should do (behave), as well as the timeframe required for the change. “SMART” objectives are Specific, Measurable, Attainable, Relevant and Time-bound.

Communication objectives should be derived from available evidence on the factors that drive or inhibit adoption by target users, as well as influencing audiences.

(b) Positioning

Positioning is the heart of the demand generation strategy and identifies the most compelling and unique benefit that the product offers the target audience. Positioning is often the emotional “hook” upon which the demand generation strategy hinges. Effective positioning moves beyond the functional benefits of the commodity and appeals to the target audience with emotional benefits.

Positioning presents the desired behavior in a way that is both persuasive and appealing to the intended audience. It provides direction for developing a memorable identity, shapes the development of messages and helps determine the communication channels to be used. Positioning ensures that messages have a consistent voice and that all planned activities reinforce each other for a cumulative effect.

As part of the positioning, a **key promise** is identified that highlights the main benefit associated with the proposed change. Changes in behavior, policies and social norms are made only because there is a perceived benefit to those changes. The benefit must outweigh the personal cost of the change.

An accompanying **support statement**, also called a “reason to believe” in marketing, describes why the audience should believe the promise. This could be based on data, peer testimonials, a statement from a reliable source or a demonstration. The key promise and support statement should include a balance of emotion and reason.

(c) Key Messages

Key messages outline the core information that will be conveyed to audiences in all materials and activities. Messages cut across all channels and must reinforce each other across these channels. When all approaches communicate iterative and harmonized key messages, effectiveness increases. Well designed messages are specific to the audience of interest and clearly reflect both a specific

behavioral determinant and positioning. They also clearly describe the desired behavior, which must be “doable” for the audience. Key messages are not the text that appears in print materials (taglines) or the words that are used to define a campaign (slogans). Creative professionals are often hired to translate key messages into a creative brief, which is a document for creative agencies or internal teams that guides the development of communication materials or media products, including taglines and slogans.

It is important that key messages are always:

- Developed on the basis of country-specific formative research.
- Derived from context-specific, strategic choices regarding segmentation, targeting and positioning.
- Addressed to known drivers of and barriers to behavior change in the country context.
- Pretested with the target audience and refined based on audience engagement.

Step 5: Determine Activities and Interventions

Activities and interventions allow for communication of key messages through a variety of communication approaches and channels. Messaging and media selection (i.e. channels) are best considered and selected in cooperation in order to effectively transmit information to the intended audiences. Activities should be carefully selected based upon type of messaging, ability to reach the intended audience through a variety of media/channels, timeline, cost and available resources.

It is helpful to refer to findings from the situation analysis to guide selection of activities and interventions. *A Theory-based Framework for Media Selection in Demand Generation Programs* (<http://sbccimplementationkits.org/demandrmnch/media-selection>) is a helpful guide to inform media selection decisions based on communications theory. Table 1 is an overview of the types of strategic approaches that can be used. Any demand generation program should include activities across a range of different intervention areas and communication channels, which communicate mutually reinforcing messages.

It also is important to consider linkages with other new or existing programs and systems, both those directly related to demand and those less closely connected, but that have an impact on demand or could be utilized to improve efficiency. The following are examples of potential areas for linkages when designing a demand generation program for misoprostol:

- Other maternal health programs that do not currently include misoprostol as a commodity.
 - Quality of care improvement initiatives for service providers/clinics.
 - Pre-service education and existing continuing education or in-service refresher training initiatives for clinical and non-clinical providers.
 - Supply chain management and market shaping.
- Private sector approaches [For a guide to PPPs in demand generation, see *The Guide to Public-Private Partnerships in Increasing the Demand for RMNCH Commodities* (available at <http://sbccimplementationkits.org/demandrmnch/public-private-partnerships>); for supply chain management, see the *Private Sector Engagement Toolkit* (available at http://www.everywomaneverychild.org/images/content/life-saving-commodities/Private_sector_engagement_A_%20toolkit_for_Supply_Chains_in_the_Modern_Context.pdf)].
 - Non-maternal health programs, such as immunization, family planning, etc.—e.g., to provide counseling, disseminate materials—at both the clinic and community levels.
 - Cross-sectoral programs—e.g., education, economic empowerment, transport.

Table 1: Overview of Strategic Approaches that Can Be Used in Demand Generation

Advocacy: Advocacy operates at the political, social and individual levels, and works to mobilize resources and political and social commitment for social change and/or policy change. Advocacy aims to create an enabling environment at any level, including the community level—e.g., traditional government or local religious endorsement—to ask for greater resources, encourage allocating resources equitably and remove barriers to policy implementation. *Scaling Up Lifesaving Commodities for Women, Children and Newborns: An Advocacy Toolkit* provides advocacy resources for utilizing the Commission platform to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. See <http://www.path.org/publications/detail.php?i=2381>.

Community-Based Media: Community-based media reach communities through locally established outlets. Such outlets include local radio stations and community newsletters/newspapers, as well as activities, such as rallies, public meetings, folk dramas and sporting events.

Community Mobilization: Community mobilization is a capacity building process through which community individuals, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their lives, either on their own initiative or stimulated by others. A successful community mobilization effort not only works to solve problems, but also aims to increase the capacity of a community to successfully identify and address its own needs. For guidance on community mobilization see *How to Mobilize Communities for Health and Social Change* (Howard-Grabman & Snetro, 2003), available at http://www.jhuccp.org/resource_center/publications/field_guides_tools/how-mobilize-communities-health-and-social-change-20.

Counseling: Counseling is based on one-to-one communication and is often done with a trusted and influential communicator such as a counselor, teacher or health provider. Counseling tools or job aids are usually also produced to help clients and counselors improve their interactions, with service providers trained to use the tools and aids.

Distance Learning: Distance learning provides a learning platform that does not require attendance at a specific location. Rather, the students access the course content either through a radio or via the Internet and interact with their teacher and fellow classmates through letters, telephone calls, SMS texts, chat rooms or Internet sites. Distance learning courses can focus on training communication specialists, community mobilizers, health educators and service providers. Additional information on eLearning can be found at Global Health eLearning Center and PEPFAR eLearning Initiative.

Information and Communication Technologies (ICTs): ICTs are fast growing and evolving platforms for electronic and digital technologies, including computing and telecommunications technologies, which enable communication and promote the interactive exchange of information. ICTs also include mobile and smart phones, the use of SMS, and social media, such as Facebook, Twitter, LinkedIn, blogs, e-Forums and chat rooms. This approach also includes websites, emails, listservs, eLearning, eToolkits and message boards. Digital media can disseminate tailored messages to the intended audience on a large scale while also receiving audience feedback and encouraging real-time conversations, combining mass communication and interpersonal interaction. *A Theory-Based Framework for Media Selection in Demand Generation Programs* (<http://sbccimplementationkits.org/demandrmnch/media-selection>) and *Utilizing ICT in Demand Generation for Reproductive, Maternal, Newborn and Child Health: Three Case Studies and Recommendations for Future Programming* (<http://sbccimplementationkits.org/demandrmnch/ict-case-studies>) are useful resources for program managers looking to utilize ICT in demand generation activities.

Interpersonal Communication (IPC)/Peer Communication: Interpersonal and peer communication are based on one-to-one communication. This could be peer-to-peer communication or communication with a community health worker (CHW), community leader or religious leader.

Mass Media: Mass media can reach large audiences cost-effectively through the formats of radio, television and newspapers. According to a review of mass media campaigns, mass media campaigns that follow the principles of effective campaign design and are well executed can have a small to moderate effect size not only on health knowledge, beliefs and attitudes, but also on behavior (Noar, 2006). Given the potential to reach thousands of people, a small to moderate effect size will have a greater impact on public health than would an approach that has a large effect size, but only reaches a small number of people.

Social Mobilization: Social mobilization brings relevant sectors, such as organizations, policy makers, networks and communities, together to raise awareness, empower individuals and groups for action, and work toward creating an enabling environment and effecting positive behavior and/or social change.

Support Media/Mid-Media: Mid-media's reach is less than that of mass media and includes posters, brochures and billboards.

Step 6: Plan for Monitoring and Evaluation (M&E)

Monitoring and evaluation (M&E) is a critical piece of any program activity because it provides data on the program’s progress toward achieving set goals and objectives.

Although planning for M&E should be included in the communication strategy, avoid developing a complete monitoring plan at the time of strategy development—e.g., indicators, sample, tools, who will monitor, frequency of data collection. At the time of strategy development, focus on the indicators that should be incorporated into the program’s plan. M&E indicators should be developed based on formative research and should indicate whether the key messages and strategies are having the desired effect on the intended audience.

A full M&E plan should then be developed as a separate program document. Developing an M&E plan should outline what indicators to track, how and

when data will be collected, and what will happen to the data once analyzed. A variety of data sources can be used to collect M&E data. It is important to assess the scope and context of the program to choose the most applicable methodology, as M&E activities vary in cost, staff and technology requirements. While some lower-cost M&E options will allow for identification of trends in demand for services, they may not be able to provide additional insight into the causal effects of activities and the function of the program. To measure cause and effect, larger program-specific data collection activities geared toward evaluation are needed. See Table 2 below for examples of low- and high-cost options.

While the collection of M&E data tends to receive the most attention, it is also critical to have a process for analysis and review of the collected data. M&E data should be used to inform program changes and new program development. It is best to build these M&E review processes into existing program management activities to allow for regular dissemination of M&E indicators.

Table 2: Examples of Low- and High-Cost Options of M&E for Demand Generation

Low-cost option: A low-cost option makes use of existing data sources and opportunities to gain insight into the program and its associations with changes in demand or uptake. However, it will only allow for the identification of trends and will not allow for the attribution of change to a given program or to program activities.

Illustrative data sources for a low-cost option include:

- Service statistics (information from clinics and providers, such as referral cards and attendance sheets).
- Communication channel statistics (information from television or radio stations on listenership of mass media activities).
- Omnibus surveys (addition of questions related to program exposure and impact to omnibus surveys).
- Provider self-reported data (small-scale surveys among providers about services rendered).
- Qualitative data (focus group discussions, in-depth interviews).
- DHS (trends in contraceptive prevalence and method mix—about every five years).

High-cost option: A high-cost option makes use of representative program-specific surveys and other data collection methods to gain considerable insight into the effects of the program and the way in which it worked.

Illustrative data sources for a high-cost option include:

- Service statistics (information from clinics and providers, such as referral cards and attendance sheets).
- Communication channel statistics (information from television or radio stations on listenership of mass media activities).
- Provider self-reported data (surveys among providers about services rendered).
- Large, nationally representative program-specific surveys (focus on issues related to knowledge, perceptions, acceptability and use of misoprostol for PPH).
- Qualitative data (focus group discussions, in-depth interviews, photo narrative, observation visits).
- Client exit interviews (exit interviews will assess user satisfaction with services delivered, including their perceptions, experience and intentions).

Indicators

M&E indicators should include process, output, outcome and impact indicators.

Process Indicators	Program Output Indicators	Behavioral Outcome Indicators	Health Impact Indicators
Measure the extent to which demand creation activities were implemented as planned.	Measure changes in audiences' opportunity, ability and motivation to use misoprostol, and the extent to which these changes correlate with program exposure.	Measure changes in audiences' behavior and the extent to which these changes correlate with program exposure.	Measure changes in health outcomes.
Example: Number of provider trainings conducted on misoprostol for the prevention and treatment of PPH.	Example: Proportion of providers who know how to administer misoprostol to prevent and treat PPH.	Example: Proportion of providers who report using misoprostol to prevent and treat PPH.	Example: Reduction in mortality from PPH in women of reproductive age.

Key issues to consider when developing indicators include:

Disaggregation: To increase the utility of M&E data, indicators should be disaggregated to facilitate more in-depth analysis of program performance. It is recommended that indicators are, at minimum, disaggregated by:

- *Gender*—Disaggregating M&E data by gender can illustrate the different impact of programs on men and women, such as attitudes toward acceptability of the commodity.
- *Age*—At minimum, programs should be able to report data separately for beneficiaries ages 15–19, 20–24 and 25–49 years old, which are the standard DHS age groups to capture major differences in these populations. Based on audience segmentation at country level, programs may wish to disaggregate the 25–49 year age group further, in order to determine the extent to which interventions are reaching those for whom they were designed.

Other factors for disaggregation may include geographic location, marital status and more.

Bias: Common biases that programmers should be aware of when designing, implementing and interpreting M&E include:

- *Self-selection bias*—for example, a caregiver who has previously sought out and received treatment for pneumonia in a child may be more interested and willing to answer a survey about childhood pneumonia compared to someone who has had no exposure.
- *Social desirability bias*—following exposure to health promotion initiatives, intended audiences may feel pressured to give “right answers” to survey questions—e.g., to report positive attitudes toward a commodity even though they do not really feel that way. As demand generation interventions are successful at shaping positive social norms, social desirability bias may become more of a challenge in M&E.



An Illustrative Communication Strategy for Misoprostol

Step 1: Analyze the Situation

Refer to page 15 for supporting guidance on this step, as well as “Step 1” on the Demand Generation Implementation Kit (<http://sbccimplementationkits.org/demandrmnch/ch-step1/>) for further resources.

Health and Commodity Context

**The majority of the information in this section is a global-level analysis for purposes of illustration. The country-specific situation analysis should be focused on the local context.*

Health Context

Globally, more than eight million of the 136 million women giving birth each year suffer from excessive bleeding after childbirth. This condition—medically referred to as PPH—causes one out of every four maternal deaths that occur annually and accounts for more maternal deaths than any other individual cause (UNCoLSC, 2012). Deaths due to PPH disproportionately affect women in low-resource countries.

Uterotonics are substances that give the uterine muscle tone, causing it to contract and cause labor or reduce hemorrhage. The World Health Organization (WHO) recommends using uterotonics during the third stage of labor to prevent PPH. Although oxytocin and misoprostol are both highly effective uterotonics, randomized controlled trials have shown that misoprostol is less effective than oxytocin and has more side effects, such as high temperature and shivering. Oxytocin is the recommended uterotonic for the prevention and treatment of PPH by the WHO. However, in settings where active management of the third stage of labor is not possible—e.g., when SBAs are not present and/or oxytocin is unavailable—WHO recommends the administration of misoprostol (600 mcg orally) immediately after the birth of the baby for the prevention of PPH (WHO, 2009, 2012).

Approximately 30 percent of births throughout the world are attended by unskilled attendants (KFF, 2012). In sub-Saharan Africa, where nearly half of the world’s maternal deaths occur, only 46 percent of deliveries are assisted by skilled attendants. Poor women and women living in rural areas are far less likely than their urban or wealthier counterparts to receive skilled care during childbirth (PATH, UNFPA, USAID, 2012; UNFPA, 2014). In some countries, as many as 90 percent of births occur at home.

Commodity Context

Misoprostol is a prostaglandin—a synthetic hormone-like substance available in an oral tablet form containing 25, 100 or 200 mcg per tablet. The tablets can be stored at room temperature, but because they can be affected by moisture, the tablets should be appropriately packaged in double aluminum blister packs. The cost per tablet from manufacturers is approximately US \$0.15. It is available from more than 50 manufacturers globally (at least 35 of which are in developing countries).

In settings where oxytocin is unavailable—due to issues, such as stock-out, high cost, cold chain issues or lack of an SBA to administer it—the administration of misoprostol (600 mcg orally) is recommended for the prevention of PPH. WHO recommends the administration of 800 micrograms of misoprostol sublingually as a third-line treatment for PPH. Because misoprostol is in tablet form, it can be administered by CHWs or even by mothers themselves when SBAs are not present; however, advance community distribution of misoprostol, such as during antenatal care (ANC), remains controversial (WHO, 2010).

Misoprostol can also be used for other indications, including to prevent and treat gastric ulcers, induce labor, treat incomplete abortion and miscarriage, and to cause abortion. Misoprostol’s ability to cause abortion is the main reason some countries are reluctant to recommend it.

Audience and Communication Analysis

A recent evidence review found 21 documents related to demand generation for misoprostol, including peer-reviewed articles, grey literature, and program reports published from 2004 to 2012 (HC3, 2013). Nine studies were from Africa, nine from Asia and one literature review spanned low-resource countries. Six additional documents on the use of uterotonics during home births were reviewed, including two from India, one on sub-Saharan Africa and one on low-income countries. The following key determinants were found to impact use of misoprostol for preventing PPH or provide insight on potential demand and the need to understand local childbirth practices.

Knowledge and perceptions: Knowledge and attitudes of PPH and misoprostol among women, community members and providers—including SBAs, TBAs and CHWs—are an important determinant of misoprostol use. For example, studies on use of uterotonics have found gaps between provider knowledge and practice, substantial incorrect use of uterotonics based on old or faulty knowledge, lack of up-to-date training, and use of outdated guidelines and protocols. Some providers incorrectly believed they could identify women at high risk of PPH, leading to sub-optimal use of uterotonics to prevent PPH (POPPHI & USAID, 2007).

In Bangladesh, misperceptions, especially concerning when to take misoprostol (either before or after delivery), were one of the main reasons for nonuse of the drug in one study (EngenderHealth/The RESPOND Project, 2010). In another study in Bangladesh, the following factors were cited as reasons that women did not take the drug after delivery: lack of knowledge about misoprostol (66 percent), belief that it is not necessary (14.4 percent), CHWs were not present or drug was not available (17.6 percent) and husbands' objection to use of the drug (1.6 percent) (Mobeen et al., 2011). In a Nigerian study, a small percentage of women who did not take the misoprostol they were given said that their male partner/family would not allow them to take it (Prata, Ejembi, Fraser, Shittu, & Minkler, 2012a).

In India, researchers found that some medical doctors and auxiliary nurse midwives were aware of and sometimes used misoprostol or oxytocin to prevent PPH; however, interviews with TBAs found that excessive bleeding and other complications were not generally recognized as complications and went untreated (Deepak, Mirzabagi, Koski, & Tripathi, 2013; Mirzabagi, Deepak, Koski, & Tripathi, 2013). In one review, Oladipo (2012) suggested that providers may be concerned that community-level use of misoprostol for PPH and advance distribution of misoprostol through ANC clinics might cause harm to women, reduce facility births or lead to use of the drug for other reasons such as abortion.

Community mobilization interventions to increase access to misoprostol for PPH prevention have shown some success. For example, in five communities around Zaria, in northwestern Nigeria, a community mobilization effort reached most women with information about PPH and misoprostol (88 percent), resulting in high comprehension of intervention messages (Prata et al., 2012a). During postpartum interviews with the 1875 women enrolled in the study, women said that TBAs, midwives and health facilities (in that order) were the main sources of information about bleeding after childbirth. These women also said that TBAs, community-oriented resource persons and midwives (in that order) were the primary sources of information about misoprostol.

Evaluation of a pilot study in Ethiopia highlighted the importance of training non-clinical workers to distribute misoprostol (Ethiopia FMoH, VSI, & DKT Ethiopia, 2008). In 2007, 128 health extension workers (HEWs), representing 120 health posts in the Amhara, Oromiya, SNNP and Tigray regions, were trained on the administration of misoprostol. The introduction of misoprostol into these communities by HEWs increased the community's willingness to seek delivery care from HEWs, increased collaboration between HEWs and TBAs, and increased demand for misoprostol from community members. Although results of the pilot study in

Ethiopia confirmed the ability of HEWs to deliver misoprostol safely, the evaluation highlighted the need for sensitization of decision makers at the district level, community education campaigns to raise awareness and the training of TBAs—who already have communities’ trust—to distribute misoprostol as well (Ethiopia FMOH et al., 2008).

These studies point to the need to ensure that TBAs, CHWs and other community-based health promoters have accurate information about PPH and misoprostol, and that facility-based providers are reassured about the safety of community-based misoprostol, including any impact on use of SBAs, and updated on PPH prevention and treatment guidelines.

Social/normative: The Ethiopia study referenced above found that while use of HEWs increased misoprostol uptake, most women remained reluctant to seek delivery care from health professionals, including HEWs (Ethiopia FMOH et al., 2008). Other studies have identified that traditional beliefs and practices prevent women from seeking timely modern health care because it would be seen as a sign of weakness—illnesses, including problems during childbirth, are seen as having spiritual causes and thus would not respond to modern medicine—or, the cultural “protocol” is to seek health solutions from the ancestors/traditional practitioner first and modern medicine as a last resort (Ngom, Debpuur, Akweongo, Adongo, & Binka, 2003).

Demand: In studies with providers in India (Deepak et al., 2013; Mirzabagi et al., 2013), providers indicated that they used uterotonics often, if not primarily, because pregnant women and family members (usually mothers-in-law) insisted on it to augment labor. This points to the possibility that pregnant women and their families may already demand misoprostol to prevent PPH.

Availability: In three studies from Bangladesh (Prata et al., 2012b; EngenderHealth/The RESPOND Project, 2010; Mobeen et al., 2011), community distribution of misoprostol helped increase its use after delivery. One study identified CHWs not being present or the drug not being available (17.6 percent) as key reasons for not using misoprostol (Mobeen et al., 2011). In a Nigerian study, the small proportion (18 percent) of women who did not take misoprostol to prevent PPH reported that they either were not offered misoprostol (60 percent), took an injection (12 percent), forgot to take misoprostol (7 percent) or, in a few cases (4–5 percent), could not find the drug, did not think they would need it or their male partner/family would not allow them to take it (Prata et al., 2012a).

Regulatory issues can impact the availability and use of misoprostol for PPH at the community level, as well as in health facilities. For example, misoprostol might only be registered for treating ulcers. Clinicians knowledgeable about misoprostol’s effectiveness in preventing PPH may choose to use misoprostol for PPH, even though it is only registered for treating ulcers. If, however, misoprostol is also registered for PPH, and there are official, widely disseminated clinical guidelines for misoprostol for PPH, demand and use of misoprostol for PPH would likely increase (PATH et al., 2012).

Regulatory issues notwithstanding, a review of literature on uterotonic use at home births found oxytocin administered in as few as 1.5 percent of home births in Bangladesh in 1994 to as many as 69 percent in India in 2005 (Flandermeyer, Stanton, & Armbruster, 2010). This suggests widespread availability at community level in some areas and very little availability in others. Among the studies reviewed—where a uterotonic was administered as part of an intervention—the most frequent use of uterotonics at home births was for the prevention of PPH. In descriptive studies that reported qualitative descriptions of uterotonic use at home births, the most common use of injectable oxytocin at home births was to accelerate labor. No studies were found that showed use of misoprostol before delivery of the baby at home births.

Example of Table to Organize Key Information

	Current Behaviors	Primary Barriers to Desired Behavior	Primary Benefits of Desired Behavior
End user/ community members (e.g., pregnant women, caregivers)	Approximately 30 percent of births worldwide are attended by unskilled attendants. In sub-Saharan Africa, where nearly half of the world's maternal deaths occur, only 46 percent of deliveries are assisted by skilled attendants. In some countries, as many as 90 percent of births occur at home. Lack of an SBA can mean increased risk of maternal death due to PPH.	Limited access for rural and poor woman to birthing services. Women not seeking SBA services. Limited misoprostol awareness and promotion. Fear of side effects and misperceptions about misoprostol (e.g., a focus on abortifacient properties).	Prevention of PPH. Reduction of maternal deaths due to PPH. Community-based distribution and use.
Providers (public and private, clinic- and community- based)	Misoprostol successfully used by both facility-based and community-based providers in a few countries, but not used on a wide scale in any countries.	Low levels of knowledge. Out-of-date protocols and lack of up-to-date training. Misoprostol not registered for full range of uses (e.g., PPH prevention). Poor perception of misoprostol because it can be used to induce abortions. Unclear if, when, and where misoprostol will be approved for community-based distribution and use.	Prevention of PPH. Reduction of maternal deaths due to PPH. No need for cold chain storage.

Step 2: Define a Vision

Refer to page 19 for supporting guidance on this step, as well as “Step 2” on the Demand Generation Implementation Kit (<http://sbccimplementationkits.org/demandrmnch/ch-step2/>) for further resources.

Illustrative Vision

Providers, women, their partners and gatekeepers see misoprostol as a valuable tool to prevent and treat PPH; they easily obtain and use it consistently at facilities and at the community level (when oxytocin is not available).

Step 3: Choose the Intended Audiences

Refer to page 19 for supporting guidance on this step, as well as “Step 3” on the Demand Generation Implementation Kit (<http://sbccimplementationkits.org/demandrmnch/ch-step3/>) for further resources.

Primary and Influencing Audience Segments *(with rationale for segment selection)*

PRIMARY AUDIENCES

Primary audience 1: Pregnant women planning to deliver at home. In general, pregnant women prepare for birth by gathering items they will need, whether giving birth at home or in a facility. Although misoprostol can be used in either facility or home-based settings, primary audience 1 will focus specifically on misoprostol for home births, where oxytocin, the first-line drug for PPH prevention and treatment in facilities, is less likely to be available and pregnant women could potentially request and use misoprostol. It might be useful to further segment this audience according to differences in their health-seeking behavior in a specific area or country. In some settings, for example, women who have more living children might be more likely to deliver at home than at a health facility. Consider segments like rural versus urban women and multiparous versus nulliparous women. This strategy provides examples for both first-time and experienced mothers-to-be.

Primary audience 2: Community-level providers. They can play a direct role in preparing for and assisting birth, including educating women and communities about the benefits of misoprostol for PPH prevention and treatment. Community-level providers are frontline workers, often working in the same community in which they live. They can include CHWs, TBAs, social workers and pharmacists, and often have a deep understanding of the customs in their community. This strategy provides examples for working with CHWs and TBAs. It is important to note that any intervention focused on reaching CHWs, with the goal of improving maternal health, would need to cover more than PPH and address other aspects of maternal health and pregnancy-related risks for better impact (e.g., nutrition, ANC visits, facility-based deliveries, recognition of danger signs for pre-eclampsia/eclampsia and sepsis). Also, supervisors need to have a clear understanding of any new roles or information these workers are being asked to provide to their communities.

It may be necessary to conduct additional research regarding local population health-seeking behaviors and providers of health information to inform the audience profile and strategic design.

INFLUENCING AUDIENCES

Influencing audience 1: Male partners, mothers and mothers-in-law. Often, they have significant influence on how women prepare for and experience birth. They might decide where and with what assistance the birth will take place, what drugs or herbs may be used, and how money will be spent.

Influencing audience 2: Facility-based providers. Facility-based providers have multiple roles: they advise pregnant women, teach by example, and are the gatekeepers and implementers of community-based distribution programs—using misoprostol when oxytocin is not available. They often have oversight of others, including community workers, who administer or promote the use of misoprostol. Some providers might educate about misoprostol or distribute the drug, but not administer it. Pharmacists may stock and dispense the drug.

Influencing audience 3: Community leaders. Particularly active community members and leaders, including religious leaders, play a key role in maintaining or changing community norms, including those related to health-seeking behavior and childbirth.

Audience Profiles

Primary Audience 1: Pregnant Women



Aminata, 20, young mother-to-be living in Zinvié, Benin

Aminata is 20 years old, married and pregnant with her first child. She completed primary school and then worked on her family's farm until she married. Now she sells clothes in the market. Her nearest health center is 20 kilometers from where she lives. She has made two ANC visits so far and expects her baby to be born in four months. She plans to give birth at home as that is what most women in her community do and the facility is too far. She is a little bit afraid because she has known or heard of several women who died in childbirth, but she is looking forward to being a mother.



Theresa, 34, experienced mother in Napula Province, Mozambique

Theresa is 34 years old, married and pregnant with her fifth child. Her first child died soon after birth, at home. She had her next child at the district hospital and the next two at home with a TBA, which she plans to do for this birth. In addition to managing her household, she sells vegetables in the local market. Even though she is six months pregnant, she has not yet had time to go and wait at the ANC clinic. She plans to do so this month. The nearest health center is 10 kilometers away.

Primary Audience 2: Community-level Providers



Kanta, 43, community health worker in Kaduna, Nigeria

Kanta is a middle-aged woman, has three children and has been trained to become a CHW (by the government and an NGO) and help her community improve health-seeking behaviors. Her training focused on identifying key diseases and health concerns for various age groups. For pregnant women, she has been trained to identify and encourage them to go for ANC regularly, and watch for danger signs. She is not completely clear about all the danger signs, but she knows of heavy bleeding and convulsions during pregnancy. Through her CHW role, she gains status and prestige within the community

(they call her "doctor") and she gets a stipend that allows her to improve her financial situation. She would like to know more about the various problems that can arise during pregnancy and childhood, and would like to have more tools so that she can better explain the importance of seeking treatment to her community. She would also like to be able to provide treatments appropriate for her skill level.



Nora, 32, traditional birth attendant in Copán Ruinas, Honduras

Nora has been delivering babies in her town for 10 years, following in the footsteps of her mother and grandmother, and their mothers and grandmothers before them. She has received limited training from a local NGO, focusing on use of a safe birth kit for clean deliveries and referring women with danger signs. Delivering babies provides income and prestige for her, and she is very concerned about the welfare of women in her village. She is happy to refer her women in the case of likely or actual emergencies,

but she does not feel that the health center staff value what she does. She has seen many cases of PPH and its consequences, and wants to be able to prevent or treat PPH during home deliveries.

Influencing Audience 1: Male Partners, Mothers, Mothers-in-law



Thomas, 35, married father of one living in Kadoma, Zimbabwe

Thomas is 35 years old with one wife and one child. He is responsible for making decisions for and about his family on everything from health care and education to regular purchases. He has never accompanied his wife to the health center and rarely goes there for himself. He is happy and proud that his wife is expecting their second child, but they do not normally discuss the pregnancy or what happens at her ANC visits—that is the women's domain. Still, he loves his wife, and wants her and their children to be healthy.



Elira, 52, expectant grandmother advising on her daughter-in-law's pregnancy in Elbasan, Albania

Elira is 52 years old and has given birth to eight children with the help of a TBA. One of her children died within weeks of his birth. Another died before age three. Some of her deliveries were difficult, but she survived and believes the old ways are good ways since they have worked for generations. When the government opened a health center in her village, she began taking her children for immunization and other types of care. She rarely seeks health care at the government facility, preferring to seek assistance from her long-trusted traditional healer. She is anxious to have grandchildren and oversees her daughter-in-law's pregnancy and delivery.

Influencing Audience 2: Facility-based Health Providers



Sadia, 27, ANC nurse in Chittagong, Bangladesh

Sadia works at a local health center and provides screening to pregnant women in the community. She is often overwhelmed by the number of women to see in a day, and she knows people complain about long lines and waiting. So, she may take shortcuts in her work or give patients limited information about what to do or expect during pregnancy and childbirth. She is unsure how often PPH occurs in her area and unaware of misoprostol as a simple, cost-effective prevention. She knows that although she is meant to see mothers four times during their pregnancy, they may: 1) delay the first visit, 2) receive ANC care from multiple care settings and/or 3) skip visits in between. As a result, she is unsure of the next time she will see her clients, as it is unlikely that she will provide all four ANC screening visits to the same woman. Typically, she does not mention PPH during the first ANC visit because she does not want to frighten the mother-to-be and thinks it is too soon for her to remember; additionally, she does not usually discuss danger signs, ask women where they intend to deliver or advise them to deliver with a skilled attendant. She is unaware of the option of providing patients with misoprostol to take home so they have it wherever they deliver.



Dr. Tilahun, 31, health officer and doctor working at a local facility in Debre Berhan, Ethiopia

Dr. Tilahun works at a local health facility and is usually supported by a few staff. He is trying to do his best to ensure that all women coming to the facility are treated or referred as appropriate. He has heard about misoprostol and knows that it can be used to prevent and treat PPH, but he is not clear about the protocol, dosage and regimen, or how to handle possible side effects. He is also concerned about fears that misoprostol might be given prematurely or used to abort. Women come to his clinic mainly for ANC and sometimes for delivery; they may also show up in case of complications, unless they head directly to the referral hospital. When a woman shows up with PPH, Dr. Tilahun may not have oxytocin available and may decide to send her to the referral center.



Anna, 53, trained birth attendant working at a local health facility in Gulu, Uganda

Anna likes her work at the health center and tends to have a good social status and recognition in her community. She has limited equipment and supplies to work with, and is worried that something could happen to the women under her care. She prefers to refer a woman, rather than try to treat her, if something happens. She is not very well informed on the active management of the third stage of labor (AMTSL), and would not know how to use misoprostol, even if it were available. However, she has heard about misoprostol and feels that it could be a reliable solution for PPH at the primary health care level when oxytocin is not available.

Influencing Audience 3: Community Leaders



Martha, 40, community leader in Garissa, Kenya

Martha leads a local women's group. She is 40 years old and has five children. She wants to see the condition and position of women in her community improve. Her group holds monthly meetings where they discuss what is and is not going well in their lives and community. They also share solutions and lessons learned. Each month they focus on a specific topic, but also open the discussion to whatever attendees are concerned about at that time. Group members contribute a small sum of money each month to the member

whose turn it is to receive. The women use this money for special purchases—e.g., seeds, equipment, health care, large household items. Martha knows the life history of everyone in the group and regularly pays them visits, listening and giving advice. She has seen too many women in her village die after giving birth. She believes in some traditional ways, but she also sees the value in modern ways, including modern health care.



Moussa, 57, community religious leader in Niamey, Niger

Moussa is 57 years old and has four children. He serves as a religious leader in his village. The men and women in his community look to him for his knowledge and wisdom on life matters as well as religious matters. He welcomes opportunities to improve health in his area, and new health programs often consult him before launching. He has a healthy, hard-working family with a very productive farm. His first wife died in childbirth. He knows first-hand how hard this was for him and his other children.

Step 4: Design Message Strategy

Refer to page 20 for supporting guidance on this step, as well as “Step 4” on the Demand Generation Implementation Kit (<http://sbccimplementationkits.org/demandrmnch/ch-step4/>) for further resources.

Primary Audience 1: Women of Reproductive Age

Objectives

By 2015, increase the percentage of women (15–49 years old) who:

1. Are aware that excessive bleeding after childbirth is dangerous, but preventable.
2. Are aware that misoprostol after birth can prevent excessive bleeding.
3. Are motivated and have the self-efficacy (awareness, knowledge and confidence) to ask an ANC provider or CHW about PPH and misoprostol.
4. Have taken misoprostol correctly to prevent excessive bleeding.
5. Would recommend misoprostol to a relative or friend to prevent excessive bleeding after childbirth.

Positioning

Knowledgeable mothers who deliver at home ask for misoprostol so they can live to raise their children.

Key Promise

Taking misoprostol immediately after childbirth can prevent excessive bleeding and could save your life. Saving your own life is the best way to help your baby live and be healthy.

Support Statement

Your newborn will have a better chance for a healthy life if you are alive and well, and able to care for her/him.

Key Messages

Key messages for pregnant women should focus on the benefits of misoprostol and facility delivery. Key information should also be provided in a simple, easy-to-understand and non-threatening way.

Illustrative examples include:

- Far too many women die from heavy bleeding after childbirth. Make sure you are not one of them.
- Heavy bleeding after childbirth is very dangerous and there are no warning signs.
- If possible, have your baby at a health facility or with a skilled attendant so you can get the best care available.
- Have a plan for the birth. Where will it happen? How will you get there? Who will help? What supplies are needed to make it clean and safe? What happens if there is an emergency?
- Well before your expected delivery date, ask your health care provider to explain about how misoprostol can prevent heavy bleeding after childbirth.
- If you plan to give birth at home, ask where you can get misoprostol and how to take it.
- Using misoprostol immediately after childbirth can save your life so you can raise your children.
- Take misoprostol tablets immediately after the baby (or all babies in the case of multiple births) is born, but before the placenta is delivered.
- Never take misoprostol tablets before the baby comes out.
- Misoprostol tablets are easy to use—just swallow them with a small amount of water.
- If you have shivering after taking misoprostol, cover yourself with a blanket.
- If you have fever after taking misoprostol and it does not go away in a few hours, take a paracetamol/acetaminophen.

Primary Audience 2: Community-level Providers

Objectives

By the year 2015, increase the percentage of community-level providers who:

1. Believe that misoprostol can prevent and treat PPH at home births.
2. Believe that providing misoprostol to prevent and treat PPH makes them better health workers and community members.
3. Are confident that they can correctly teach pregnant women how to use misoprostol to prevent PPH.
4. Are confident that they can educate communities about PPH, and the safety and effectiveness of using misoprostol to prevent it.
5. Know where to get misoprostol.
6. Correctly demonstrate how to counsel women about PPH and its prevention and treatment, including referral when bleeding is still excessive.
7. Correctly provide and report use of misoprostol for PPH during home deliveries.
8. Feel that they have support to provide misoprostol to women.

Positioning

Women trust community-level providers with their health and the health of their families. Community-level providers help save lives, improve community well-being and increase their value to the community by providing and educating about misoprostol to prevent PPH.

Key Promise

Misoprostol can help you save lives in your community by reducing PPH.

Support Statement

Community-based workers and volunteers in many countries are successfully recommending and/or administering misoprostol to help families. It makes them proud and improves relationships with the community.

Key Messages

Key messages for community-based providers should focus on creating confident, capable providers that believe in the safety and effectiveness of misoprostol for the third stage of labor.

Illustrative examples include:

- Heavy bleeding after childbirth is a life-threatening condition and there are no warning signs.
- When a woman cannot use a skilled provider who has the first-line treatment, community-based providers like you can save lives and reduce suffering by providing misoprostol.
- Women in your community depend on you to protect their health and the health of their children.
- One of your most important jobs is to talk with pregnant women, their families and community members about the risks of childbirth and opportunities for making birth safe.
- Misoprostol is easy to use.
- Misoprostol is a tablet—not an injection—that is swallowed after delivery of the baby to prevent bleeding after childbirth that can lead to death.
- Misoprostol should never be taken before the baby comes out.
- Misoprostol is available at [the facility] or from community-based workers like you for women who deliver at home.
- To prevent excessive bleeding after childbirth: immediately after the birth of the baby, check to make sure there is no twin. Before delivery of the placenta, the mother swallows 600mcg (3 tablets) of misoprostol with water.

Key Messages (continued)

- Monitor the woman closely. Expected symptoms are shivering, vomiting/nausea and fever. Symptoms typically resolve on their own in a short while. For chills, cover the woman with a blanket. For fever, apply cool, wet cloths.
- To treat excessive bleeding after childbirth: if a mother has not already taken misoprostol, give her four tablets of misoprostol (800 mcg to swallow or let dissolve under her tongue) to stop the excessive bleeding. Refer her to a health facility immediately or monitor the mother closely and transfer her to the nearest facility if bleeding continues. (Adapt to national guidelines.)
- Emphasize to pregnant women that the facility is the safest place to deliver.

Influencing Audience 1: Male Partners, Mothers and Mothers-in-law

Objectives

By the year 2015, increase the percentage of partners, mothers, and mothers-in-law who:

1. Are aware that excessive bleeding after childbirth is a major killer of women.
2. Have heard of misoprostol.
3. Believe that misoprostol can prevent excessive bleeding after childbirth.
4. Say they approve of the use of misoprostol to prevent PPH.
5. Know that misoprostol should be taken right after the child is born.
6. Encourage the pregnant woman to have misoprostol on hand during delivery.
7. Encourage the pregnant woman to use misoprostol after birth and before delivery of the placenta.

Positioning

Misoprostol is a smart, easy way to help protect your family—it can save the mother's life, and the best way to ensure the baby survives and thrives is to ensure the mother is alive and healthy. There is nothing like a mother's love and devotion to her child.

Key Promise

Misoprostol and other modern care improve the newly delivered mother's chances of survival, which makes family life better for all. Misoprostol can also save the family a lot of money that would need to be spent on emergency and long-term care if the mother has excessive bleeding. When you help make this possible, you are even more respected and appreciated.

Support Statement

In communities where misoprostol is being used, fewer women are suffering and dying from excessive bleeding after childbirth.

Key Messages

Key messages should focus on benefits and action steps.

Illustrative examples include:

- Many women die in childbirth due to excessive bleeding.
- If the mother is alive and healthy, the child is more likely to survive and grow up healthy. In fact, the whole family is likely to be healthier and do better.
- You have the power to help your family by ensuring that your loved one has misoprostol when it comes time for her to deliver.
- Encourage the pregnant woman to attend the ANC clinic to help ensure she and the child stay healthy.
- Before the baby is due, help decide where the woman will deliver, what supplies she needs, who will help and how to get to the health center if needed.
- Encourage the woman to deliver at a health center or with an SBA.
- Emergency treatment is difficult and expensive. It is much better to prevent emergencies.
- An inexpensive, easy-to-use drug called misoprostol can prevent excessive bleeding after childbirth.
- Although the health facility is the safest place to give birth, misoprostol can also be safely used at home.
- Be like others in your community who protect the health of the women in their family—ensure she has misoprostol when it comes time for her to deliver.
- Knowledge is power. If you know what to expect during pregnancy and delivery, you can help ensure that mother and child are safe.

Influencing Audience 2: Facility-based Health Providers

Objectives

By 2015, increase the percentage of facility-based health providers who:

1. Are aware of that misoprostol can save lives when used for PPH prevention and treatment.
2. Are aware of and understand the guidelines for preventing and treating PPH, including use of oxytocin as the preferred drug.
3. Say they support the use of misoprostol as a second-line drug for PPH prevention and a third-line drug for PPH treatment.
4. Are motivated to maintain sufficient stocks of the drug.
5. Are motivated and have the skills and self-efficacy to counsel patients on the benefits of the drug and to administer it appropriately.
6. Report they believe that community-level use of misoprostol is a safe and effective way to save lives and money.
7. Permit or participate in distribution of misoprostol at ANC clinics or by CHWs and/or TBAs for PPH prevention and treatment.
8. Ensure that misoprostol is available as second-line treatment for PPH prevention in facilities and for use at community level.

Positioning

Facility-based providers can increase their influence and impact by facilitating community-level PPH prevention using misoprostol. Misoprostol saves lives, livelihoods, time and money. It is good for women, families, communities, health workers and society. It extends the reach of health providers beyond the facility, and into homes and communities. You can save more than just the women at your clinic!

Key Promise

Endorsing and facilitating community-based use of misoprostol will reduce the number of PPH cases that need to be referred to you and save the lives of women who would arrive too late or not at all. Clients and their families will appreciate your facility and increase their trust in it. You and your facility will be recognized for reducing the leading cause of maternal deaths in your country and helping to reach MDG 5—improve maternal health. In addition, you can very easily save lives by using misoprostol in the active management of third stage labor when oxytocin is not available. Misoprostol is inexpensive and easy to store, and potential side effects are easily managed.

Support Statement

WHO recommends the use of misoprostol as a second-line drug for prevention of PPH (WHO, 2009). In 2011, a WHO Expert Committee on the Selection and Use of Essential Medicines included misoprostol for prevention of PPH on its Model list of essential medicines. The International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) jointly called for national regulatory and policy makers to approve misoprostol for PPH prevention and treatment and advocate the administration of misoprostol to reduce the occurrence of PPH where oxytocin is not available and birth attendants have limited skills. Ten years of data from developing countries demonstrate the safety and usefulness of misoprostol for saving mothers' lives. Additionally, data from Afghanistan, Indonesia, Nepal and other countries show that the introduction of misoprostol for home births can actually increase the proportion of facility deliveries in the intervention areas, suggesting an improvement in linkages and trust between communities and facilities.

Key Messages

Key messages for facility-based providers should be focused on their highly influential role in health decision making and on building confident, capable providers that believe in the safety and effectiveness of misoprostol for preventing and treating PPH.

Illustrative examples include:

- PPH is likely the number one or two cause of maternal deaths in your facility and community.
- Oxytocin is the first-line drug for preventing and treating PPH.
- Misoprostol is a safe and effective second-line drug for preventing PPH and a third-line drug for treating PPH.
- Misoprostol comes in tablet form and is easy to administer. You can be confident about it being administered at the right dose and right time.
- Misoprostol can be stored at room temperature, preferably in double aluminum blister packs.
- Discuss with women where they can obtain misoprostol to be prepared for delivery.
- Provide women with misoprostol during ANC so they have it during delivery.
- Use pictures (posters, pamphlets) and provide clear instructions to pregnant women how and when to use misoprostol if they deliver at home. Have them repeat the instructions to you in their own words. Do this at every ANC visit, and provide them with the tablets before the last trimester.
- Community-based misoprostol can help improve facility statistics and lower costs.
- Studies and projects from at least 10 countries demonstrate that CHWs, TBAs and other community-level workers can safely and effectively administer misoprostol at community level without direct supervision of a clinician and that women who receive it this way are highly satisfied with the outcome.
- Studies also show that programs that promote community-level use of misoprostol for PPH might actually increase the percentage of facility births by building linkages and trust with the health system. In this way, community-based misoprostol can be part of a transition strategy to increase facility births.
- Help your community bring down maternal mortality—make misoprostol for PPH available for all births.
- Using misoprostol when oxytocin is not available will help you save lives, save time, reduce emergency referrals and increase community confidence in you and your facility.
- To prevent PPH, give 600 mcg of misoprostol orally after ensuring the baby has been delivered and there is no twin, and before delivery of the placenta.
- Monitor the woman closely. Potential side effects include shivering, fever and vomiting/nausea. Symptoms typically resolve on their own, but you can manage shivering by placing a blanket on the woman. Manage fever with paracetamol/acetaminophen and by placing a wet cloth on the forehead.
- To treat PPH, administer 800 mcg sublingually and refer the woman to a higher-level facility. (Adapt to national guidelines.)
- Misoprostol should not be administered for the prevention of PPH while the woman is still pregnant. (If used to induce labor, guidelines call for a much smaller dose.)

Influencing Audience 3: Community Leaders

Objectives

By 2015, increase the percentage of community leaders who:

1. Recommend that pregnant women attend ANC clinics.
2. Recommend that women give birth at a health facility or with an SBA whenever possible.
3. Have heard of misoprostol.
4. Believe that misoprostol can prevent excessive bleeding after childbirth.
5. Encourage families in the community to have misoprostol on hand at childbirth.
6. Encourage TBAs to participate in training on misoprostol and safe birth.

Positioning

Community leaders help their communities and extend their influence by encouraging ANC, skilled delivery and misoprostol for PPH to improve family and community health.

Key Promise

Supporting misoprostol use to prevent PPH will earn you respect and trust because it will save mothers' lives and make things easier for families. Misoprostol and other modern care can help prevent new mothers from bleeding to death after delivery or from losing so much blood that they become very weak for a long time. Having healthy mothers can help ensure having healthy children for a strong community.

Support Statement

In communities where misoprostol is being used, fewer women are suffering and dying from excessive bleeding after childbirth. Community leaders play a role in making this happen.

Key Messages

Key messages for community leaders should focus on their role as well as misoprostol's benefits.

Illustrative examples include:

- An inexpensive, easy-to-use drug called misoprostol can prevent excessive bleeding after childbirth.
- Misoprostol can save lives, money and families.
- You can help reduce the number of women in your community who die in childbirth.
- Teach your community about the benefits of misoprostol.
- Healthier, more economically stable families make better communities.
- Invite a health provider to come speak to your group about safe motherhood and listen to what challenges your community faces.
- Encourage the women in your community to attend ANC clinics.
- Encourage the women in your community to deliver with a skilled attendant.

Step 5: Determine Activities and Interventions

Refer to page 21 for supporting guidance on this step, as well as “Step 5” on the Demand Generation Implementation Kit (<http://sbccimplementationkits.org/demandrmnch/ch-step5/>) for further resources.

Wherever possible, messaging about misoprostol should be integrated into broader maternal health behavior change efforts. A review of misoprostol introduction and demonstration studies suggests the following as a successful minimum package of interventions:

- Training of service providers at facility and community level, including IPC, job aids and refreshers.
- Group and individual counseling and education, especially by providers.
- Materials to use in group and individual counseling and education (e.g., flipchart, pamphlet/brochure, package insert).
- Interventions to remind pregnant women and their support system of when and how to use misoprostol (e.g., role play, sticker for inside home, package insert, messages printed on useful items such as scarves).
- Interventions to remind and assist TBAs and other community-level providers (e.g., clean birth kit including misoprostol and instructions for its use and managing side effects).
- On a larger scale, it will be important to have interventions that address policy and practice, supply and monitoring.

Suggested approaches and activities and illustrative examples are presented here as appropriate choices for communicating to primary and influencing audiences about misoprostol. These suggestions are a starting point, and close collaboration with communication and creative professionals can help ensure that design and execution are innovative and compelling.

Mass Media

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Short-form mass media	<ul style="list-style-type: none"> • Develop radio public service announcements (PSAs) on misoprostol (e.g., of real women talking about how happy they were to have misoprostol after childbirth and of men who wish they had known about misoprostol in time to save their partner). • Where TV coverage is good, could do TV spots as above and on facility delivery/safe birth, including mention of main cause of maternal death. 	To increase product awareness and knowledge of benefits.	<p>Pregnant women, male partners of pregnant women, gatekeepers/ extended family, communities/ leaders,</p> <p>Influencing: Health providers (facility- and community-level)</p>
Long-form mass media	<ul style="list-style-type: none"> • Integrate misoprostol into multi-episode radio drama serial. • Produce radio call-in shows that include misoprostol and excessive bleeding as a topic. 	<p>To stimulate social dialogue about everyone's role in protecting maternity.</p> <p>To shift social norms around assisted childbirth.</p>	Pregnant women, male partners of pregnant women, gatekeepers/ extended family, communities
Print media	Develop/adapt take-home brochures/leaflets and posters on misoprostol (including where to get it), and stickers to remind women when to take misoprostol.	<p>To increase product knowledge of where to find quality services.</p> <p>To provide reminders.</p>	Pregnant women, male partners of pregnant women
Digital media and mHealth	<ul style="list-style-type: none"> • Produce SMS service on misoprostol benefits, reminders of when to take it, reminders to seek ANC and misoprostol suppliers (preferably in the context of safe birth messaging). • Host maternal health hotline (phone and/or SMS-based). 	<p>To increase product awareness and knowledge.</p> <p>To stimulate social dialogue.</p>	Pregnant women, male partners of pregnant women, community-based providers

Clinic-Based Services

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Clinic services	<ul style="list-style-type: none"> • Train providers in AMTSL, including the use of oxytocin or misoprostol if oxytocin is not available. • Discuss PPH and misoprostol during ANC education sessions. • Develop flipchart for group and individual education. • Develop safe birth video for clinic waiting room. • Develop and disseminate PPH/misoprostol guidelines. • Develop misoprostol job aids (instructions, algorithms, checklists, etc.) on when and how to use, management of side effects. • Develop low- and non-literate materials for take-home misoprostol. • Train pharmacists on misoprostol storage and dispensing. • Develop posters for awareness, teaching and reminding. 	<p>To increase product awareness/knowledge.</p> <p>To establish quality standards to ensure good service for clients.</p> <p>To improve provider-client interaction.</p>	Clinical providers, women
Digital/distance learning	<ul style="list-style-type: none"> • Develop distance learning/online module for clinicians, preferably integrated into an existing maternal health distance learning program. • Develop short video clips and print FAQs that model education and counseling that can be disseminated via video, smartphones, tablets and online. • Use Twitter or other social media as a discussion forum to share program implementation ideas, problems and solutions. 	To increase and refresh knowledge and skills.	Clinical providers; ANC and non-clinical providers; district/facility-level decision makers, supervisors, implementers

Community-Based Services, Outreach and Community Approaches

Intervention Area	Illustrative Activities	Purpose	Intended Audience
CHW outreach	<ul style="list-style-type: none"> • Train CHWs to conduct community-based education and referral for safe birth. • Develop and produce radio distance learning program on safe birth, including misoprostol for PPH, for community workers that model positive behaviors and relationships with communities and referral clinics. • Establish CHW radio listening groups for distance learning program. • Develop/adapt materials and job aides (flipbooks, pamphlets, checklists, referral cards, etc.) to provide guidance on counseling on safe birth, including PPH and misoprostol. 	<p>To improve knowledge and skills.</p> <p>To provide peer-supported learning opportunities.</p> <p>To ensure quality education and referral.</p> <p>To promote quality services.</p>	Community-level providers
CHW/TBA administration/distribution	<ul style="list-style-type: none"> • Train and equip TBAs for safe delivery, including misoprostol. • Train CHWs to counsel pregnant women and distribute misoprostol to women by 32 weeks with low-literate take-away instructions on usage. • Develop an easy-to-keep and carry job aid. • Develop sticker to remind pregnant women when to take misoprostol. • Develop pictorial pamphlet with key messages for new mother/family. 	<p>To increase understanding of misoprostol and its use.</p> <p>To provide community-based counseling and services for women.</p> <p>To promote proper use of misoprostol among service providers and patients themselves.</p>	Community-level providers
Community dialogues	<ul style="list-style-type: none"> • Hold community dialogues around maternal health, including PPH and misoprostol, using satisfied users (and their partners and gatekeepers) as key advocates. • Organize discussion groups for men, women and/or couples, other family members (e.g., mothers and mothers-in-law) and community/religious leaders as appropriate. 	<p>To encourage social dialogue on preventing maternal deaths.</p> <p>To increase social support for safe birth using misoprostol.</p>	Women, male partners of pregnant women, gatekeepers/extended family, communities

Community-Based Services, Outreach and Community Approaches (continued)

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Champions	<ul style="list-style-type: none"> • Identify satisfied users as community advocates. • Identify “everyday heroes”—men and women in the community who support safe birth and are helping to ensure the health of their families—and celebrate them at community events and through community media and mass media. • Identify men who have suffered the loss of a wife in childbirth and want to save other families from such tragedy. Have them speak at community meetings, in mass media, at work where appropriate and one-on-one with their neighbors. 	<p>To encourage social dialogue on preventing maternal deaths.</p> <p>To increase social support for safe birth.</p>	Women, male partners of pregnant women, gatekeepers/extended family, communities
Social franchising/ service promotion	<ul style="list-style-type: none"> • Establish network of pharmacies to stock, dispense and instruct on misoprostol use. • Develop and disseminate materials to pharmacies on misoprostol benefits and use. 	To promote quality brand of misoprostol.	Pharmacies, pregnant women and their support system

Structural

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Policy and guidelines	<ul style="list-style-type: none"> Disseminate guidelines for use of misoprostol to prevent and treat PPH in absence of oxytocin. Twitter feed or other social media on international, national and local progress toward making misoprostol available at community level; local impact; studies/ reports published; implementation tips; and other relevant information. <p><i>Scaling Up Lifesaving Commodities for Women, Children and Newborns: An Advocacy Toolkit</i> provides advocacy resources for utilizing the Commission platform to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. See: http://www.path.org/publications/detail.php?i=2381</p>	<p>To ensure consistent availability and use of misoprostol.</p> <p>To address any abortion-related or safety concerns.</p> <p>To enable community-level distribution and use of misoprostol.</p>	National and district health officials
Pre-service/ in-service training	Integrate misoprostol into pre-service and in-service training for providers, including pharmacists, doctors, nurses, midwives, CHWs, etc.	To increase awareness.	Pharmacists, doctors, nurses, midwives, CHWs, etc.

Step 6: Plan for Monitoring and Evaluation (M&E)

Refer to page 24 for supporting guidance on this step, as well as “Step 6” on the Demand Generation Implementation Kit (<http://sbccimplementationkits.org/demandrmnch/ch-step6/>) for further resources.

The following indicators (including potential data sources) are used for measuring program inputs, outputs, outcomes and impact.

Facilities/providers (by place of birth/type of provider, as appropriate):

- Number of doses of misoprostol ordered. (Monitoring)
- Number of doses of misoprostol used. (Monitoring)
- Number of doses of misoprostol distributed through ANC clinics. (Monitoring)
- Number of doses of misoprostol provided to community-based workers. (Monitoring)
- Number of PPH referrals made. (Monitoring)
- Number of PPH referrals received. (Monitoring)
- Number of pharmacies that stock misoprostol in appropriate packaging. (Evaluation)
- Proportion of providers trained to use misoprostol for PPH. (Monitoring)
- Number of copies of updated clinical guidelines disseminated. (Monitoring)
- Proportion of providers who have seen guidelines for the use of misoprostol to prevent and treat PPH. (Evaluation)
- Proportion of providers who say they believe community-based misoprostol for PPH is safe and effective. (Evaluation)
- Proportion of providers who say they support community-based distribution of misoprostol for PPH. (Evaluation)
- Proportion of providers who say they counsel pregnant women to obtain misoprostol for PPH during home deliveries. (Evaluation)
- Proportion of providers who know how to administer misoprostol to prevent and treat PPH. (Evaluation)
- Proportion of providers who report using misoprostol. (Evaluation)
- Proportion of births where misoprostol is used correctly. (Evaluation)
- Number of reported cases of PPH. (Evaluation)
- Proportion of maternal deaths attributed to PPH. (Evaluation)

Women:

- Number of individual education/counseling sessions held with pregnant women. (Monitoring)
- Proportion of women who report they know where to access PPH information and services. (Evaluation)
- Proportion of women who know that excessive bleeding after childbirth is dangerous, but preventable. (Evaluation)
- Proportion of women who know that taking misoprostol after birth can prevent excessive bleeding. (Evaluation)
- Proportion of women who report they have been given misoprostol to prevent excessive bleeding. (Evaluation)
- Proportion of women who report having excessive bleeding after birth. (Evaluation)
- Proportion of new mothers who report using misoprostol correctly. (Evaluation)
- Proportion of women who report being satisfied with misoprostol use after birth. (Evaluation)
- Proportion of women who report they would be willing to use misoprostol in their next pregnancies. (Evaluation)
- Proportion of women who report they would recommend misoprostol to a relative or friend to prevent excessive bleeding after childbirth. (Evaluation)

Male partners/gatekeepers/communities:

- Number of individual education/counseling sessions held with men/gatekeepers. (Monitoring)
- Number of community education/sensitization sessions held. (Monitoring)
- Proportion of male partners/gatekeepers/community members who know that excessive bleeding during childbirth is a leading cause of maternal deaths. (Evaluation)
- Proportion of male partners/gatekeepers/community members who have heard of misoprostol. (Evaluation)
- Proportion of male partners/gatekeepers/community members who know that misoprostol can prevent excessive bleeding after childbirth. (Evaluation)

Communication channels:

- Main sources of information about misoprostol by channel. (Evaluation)
- Number of spots aired on radio or other media. (Monitoring)
- Proportion of intended audience who report hearing radio (or other) spots related to safe birth and misoprostol. (Monitoring)

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